

**IN THE IOWA SUPREME COURT**

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**NO. 14-1682**

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**ALAN ANDERSEN, Individually and as  
Injured Parent of CHELSEA ANDERSEN  
and BRODY ANDERSEN and DIANE  
ANDERSEN, Wife of Alan Andersen,**

**Plaintiffs-Appellants,**

**vs.**

**SOHIT KHANNA, M.D., and IOWA  
HEART CENTER, P.C.,**

**Defendants-Appellees.**

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**APPEAL FROM THE IOWA DISTRICT COURT  
IN AND FOR POLK COUNTY  
THE HONORABLE MICHAEL D. HUPPERT**

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**APPELLANT'S BRIEF**

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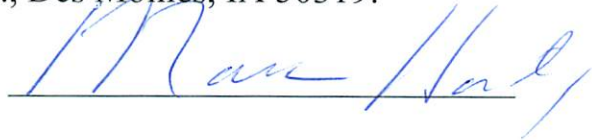
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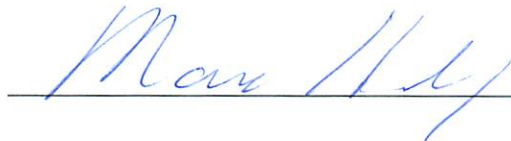
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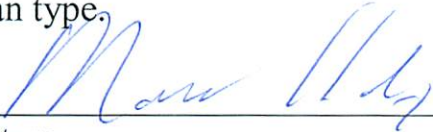
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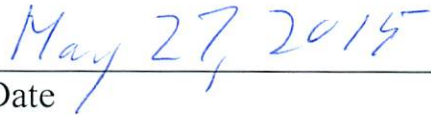
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## STATEMENT OF ISSUES PRESENTED FOR REVIEW

### **I. THE TRIAL COURT ERRED WHEN IT DENIED PLAINTIFFS THE OPPORTUNITY TO PRESENT THEIR CLAIM OF NEGLIGENT FAILURE TO OBTAIN INFORMED CONSENT TO THE JURY.**

*Barriocanal v. Gibbs*, 697 A.2d 1169 (Del. 1997)

*Bray v. Hill*, 517 N.W.2d 223 (Iowa Ct. App. 1994)

*Coralville Hotel Assocs., L.C. v. City of Coralville*, 684 N.W.2d 245 (Iowa 2004)

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Aslam Ejaz, MD, MPH, et al., *Choosing a Cancer Surgeon: Analyzing Factors in Patient Decision Making Using a Best-Worst Scaling Methodology*, 21 Annals of Surgical Oncology (12)(Nov. 2014)

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**II. THE TRIAL COURT ERRED IN REFUSING TO ALLOW PLAINTIFFS TO PRESENT REBUTTAL TESTIMONY FROM PLAINTIFFS AND FROM DR. AROESTY TO ADDRESS THE DEFENSE'S EXPERT TESTIMONY THAT PLAINTIFF HAD A "SUPER BAD HEART" WITH INSUFFICIENT RESERVES THAT CREATED A GREATER RISK THAT IT WOULD FAIL.**

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*Fry v. Blauvelt*, 818 N.W.2d 123 (Iowa 2012)

*Hall v. Jennie Edmundson Memorial Hosp.*, 812 N.W.2d 681 (Iowa 2012)

*Johnson v. Van Werden*, 125 N.W.2d 782, 785 (Iowa 1964)

*Meier v. Senecaut*, 641 N.W.2d 532 (Iowa 2002)

*Salami v. Von Maur, Inc.*, No. 3-346/ 12-0639 (Iowa Ct. App. 2013)

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*Coker v. Abell-Howe Co.*, 491 N.W.2d 143 (Iowa 1992)

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*Meier v. Senecaut*, 641 N.W.2d 532 (Iowa 2002)

*Mulhern v. Catholic Health Initiatives*, 799 N.W.2d 104 (Iowa 2011)

*Sonnek v. Warren*, 522 N.W.2d 45 (Iowa 1994)

Restatement (Second) of Torts § 300

## **ROUTING STATEMENT**

Pursuant to Iowa R. App. P. 6.1101(3)(a), this case presents the application of existing legal principles, and as such is eligible for transfer to the court of appeals.

## **STATEMENT OF THE CASE**

### **Nature of the Case**

This medical malpractice action arises out of the performance of an aortic heart valve replacement via a Bentall procedure. In their petition and at trial, Plaintiffs alleged, in relevant part to this appeal, that the surgeon who performed the procedure, Sohith Khanna, M.D. (Dr. Khanna), negligently failed to obtain Plaintiff's informed consent as he failed to inform Plaintiffs of the risks associated with the surgery, including that Plaintiff had a "super bad heart" that may have had insufficient reserves to recover, and thus greatly increased the risk of an unsuccessful surgery; Plaintiffs also allege that Dr. Khanna failed this duty when he failed to inform Plaintiffs that he had not trained for, and had never performed, the complex Bentall procedure previously.

Plaintiffs also alleged that Dr. Khanna's performance of a surgery that he had not trained for and had no experience with was negligence, as was his

failure to obtain the assistance of a qualified and experienced cardiac surgeon.

In this appeal, Plaintiffs aver the trial court erred in refusing to allow them to try the issue of lack of informed consent or to present testimony regarding this in rebuttal, while at the same time allowing the defense to present testimony regarding informed consent, as well as highly prejudicial testimony that Plaintiff Alan Andersen had a "super bad" and "weak" heart – together implying that he was properly informed before the surgery, and chose to take the risk; in addition Plaintiffs aver that the trial court erred in refusing to allow them to present a specification of negligence to the jury alleging that Dr. Khanna was negligent for conducting a surgery for which he was unqualified.

### **Course of Proceedings**

Plaintiffs' petition was filed on September 26, 2005 against, in relevant part, Defendants Sohit Khanna (Dr. Khanna) and Iowa Heart Center (IHC). An amended petition was filed on August 19, 2008 to add Plaintiff Alan Andersen's (Mr. Andersen) employer in response to an order regarding subrogation.

Defendants' motion for partial summary judgment on Plaintiffs' informed consent claim regarding Dr. Khanna's failure to inform Plaintiffs

that he had never previously performed a Bentall procedure was granted on June 15, 2010.

In that June 15, 2010 order, the Polk County District Court, Judge Rosenberg, held that Iowa informed consent law does not require disclosure of the personal characteristics or experience of the physician, but does require "disclosure to the patient of all known material information concerning the procedure to be performed which includes disclosing the material risks concerning a particular procedure." [App. 162]

On September 20, 2011, the district court, Judge Stovall, confirmed that Plaintiffs "shall be allowed to present evidence relating to . . . the Plaintiff's increased mortality risk and apprising the Plaintiff of the same." [App. 294] In that same pre-trial ruling, although Defendants had requested a motion in limine completely excluding any reference or evidence of "allegations of informed consent," Judge Stovall sustained the motion only "as to negligent credentialing." [App. 295]

The first trial on October 31, 2011 was declared a mistrial due to Plaintiffs' previous attorney, Mr. Palagi's, representation to the jury that Dr. Khanna had lied. A second trial, commencing on April 15, 2013, was also declared a mistrial, this time due to the inappropriate presentation of medical expense evidence, which had previously been excluded.

Immediately prior to the third trial, despite the court's earlier orders, Judge Huppert ruled that all reference to Plaintiff's informed consent claim, including that pertaining to advising Plaintiff of his mortality risk, was prohibited. After a jury trial, on July 22, 2014, the Polk County District Court entered judgment in favor of Defendants, and on July 23, 2014, entered the verdict. Plaintiffs filed a motion for new trial on July 31, 2014, and a supplemental motion for new trial on August 7, 2014. Defendants filed a resistance on August 22, 2014. The court denied Plaintiffs' motion for a new trial on September 17, 2014, and Plaintiffs filed their notice of appeal on October 7, 2014.

### **STATEMENT OF THE FACTS**

Mr. Andersen was born on May 12, 1952 with only two flaps in his aortic heart valve instead of the usual three (congenital bicuspid aortic valve), a condition that, by the time he reached his 50s, had led to a narrowing of the aorta (aortic stenosis), leakage from the valve (aortic insufficiency), enlargement of the heart (hypertrophy, from the years of working overtime due to the valve defect), and enlargement of a portion of his aorta (aorta aneurysm). [App. 375 (Tr. p. 279, l. 21-25; p. 280, entire); App. 376 (Tr. p. 281, l. 1-4, 19-23); App. 397 (Tr. p. 417, l. 1-11); App. 431

(Tr. p. 878, l. 10-13); App. 440 (Tr. p. 964, l. 2-9); App. 441 (Tr. p. 968, entire); App. 485 (Supp. Tr. p. 26, l. 20-25)]

He had been aware of his condition from an early age, and from the age of 7, he had either annual or bi-annual check-ups. [App. 432 (Tr. p. 885, l. 7-17)] Nonetheless, he suffered from few symptoms until the early 2000s. In December 2003, during his annual visit with his University of Iowa cardiologist, Mr. Andersen informed Dr. Brown that he had become short of breath while hunting deer that past fall. [App. 434 (Tr. p. 897, l. 12-21)] Knowing he would inevitably need surgery, together they agreed that he could have the elective procedure done closer to his home in Des Moines at Iowa Heart Center. [App. 435 (Tr. p. 898, l. 1-18)] Dr. Brown then referred him, and at his initial consultation, Mr. Andersen met with cardiologist Atul Chawla, M.D. (Dr. Chawla). [App. 435 (Tr. p. 898, l. 23-25; p. 899, l. 1-7)]

In an offer of proof, Mr. Andersen testified that during the consultation, Dr. Chawla, told him that, "all of my doctors here are experienced and done hundreds of these surgeries. So, you know, led me to believe that they all can do it." [App. 434 (Tr. p. 895, l. 14-25)] Also in that offer of proof, Mr. Andersen testified that had he been told that the surgeon who was to perform the procedure had never done the surgery before, he

"would not have done it . . . [and] would have went back to Iowa City probably or asked for another doctor." [App. 434 (Tr. p. 896, l. 4-11)]

Ignorant of this fact, Mr. Andersen accepted Dr. Chawla's referral to Sohith Khanna, M.D. (Dr. Khanna), with whom he and his wife met on January 9 and 14, 2004, with the surgery to be performed on January 22, 2004. [App. 435 (Tr. p. 899, l. 2-22; p. 900, l. 7-9)] After consulting with Dr. Khanna, Mr. Andersen and his wife, Plaintiff Diane Andersen (Mrs. Andersen), anticipated that he "would be in the hospital five to seven days, and then I'd be recovering at home," because, according to Mrs. Andersen she had been led to believe that, "although it was open heart surgery, [it was] a routine surgery." [App. 430 (Tr. p. 858, l. 23-25; p. 859, l. 1-3); App. 436 (Tr. p. 902, l. 15-21)] Dr. Khanna told Mr. Andersen that he would "probably be well enough to take my trip," which he had planned to do in April 2004. [App. 436 (Tr. p. 902, l. 15-21)]

In an offer of proof, Mr. Andersen testified that he believed the procedure he was having was a "traditional Bentall elective surgery," and nothing was said of any lower likelihood of success. [App. 507 (Supp. Tr. p. 87, l. 18-25); App. 508 (Supp. Tr. p. 88, l. 1-5, 21-25)]

Contrary to their expectations and information, and never mentioned to the Andersen's until after the surgery, the defense asserted that Mr.

Andersen's heart, prior to the procedure, was in a very weakened state that made it much less likely that he would have a successful surgery.

Defendants' expert, cardiac pathologist Henry Cuenoud, M.D. (Dr. Cuenoud), believed that prior to surgery, Mr. Anderson had a heart "like a marathon runner . . . arriving at the end of a marathon. You cannot run another marathon," and as a result, he, like "some patients can't tolerate that," and their hearts are unable to revive after surgery. [App. 452 (Tr. p. 1056, l. 14-17); App. 455 (Tr. p. 1075, l. 2-17)] During his testimony, Dr. Cuenoud stated that Mr. Andersen's heart was "weak or weaker" several times. [App. 455 (Tr. p. 1076, l. 6-15)]

Likewise, Defendant's expert, cardiovascular surgeon, Dr. Frazier Eales (Dr. Eales), testified that due to Mr. Anderson's hypertrophy, "[i]t makes it more difficult to penetrate the depth of this muscle with the cardioplegia you're giving, no matter how you give it, no matter how much you give. It's simply a somewhat dicier proposition." [App. 486 (Supp. Tr. p. 27, l. 3-7)]

Dr. Eales also testified that, despite what the Andersen's were told and led to believe, "[t]here's no question this was a higher risk operation than the standard elective short procedure," because his sick, "super bad heart" caused him to have less "reserve strength," to help it revive after the surgery.

[App. 494-496 (Supp. Tr. p. 35, l. 22-25; p. 36, l. 1-7; p. 37, l. 3-4) App. 498 (Supp. Tr. p. 40, l. 1-16); App. 506 (Supp. Tr. p. 77, l. 2-9)]

The trial court refused to allow the Andersen's to rebut this testimony (or ever present their claim of lack of informed consent), even though Dr. Eales was allowed to testify as to his usual method for obtaining it, thereby falsely implying that this had also happened with the Andersen's: "[w]hen I operate on somebody, I frequently tell them this . . . . The fact we can do this successfully depends on whether the people have reserve capacity . . . . And we rely on every patient to have enough reserve there to get through the injury to the heart. . . ." [App. 495 (Supp. Tr. at 36, l. 8-22)]

During offers of proof, Mr. Andersen testified that had he been counseled by his doctors that he had a "25 percent chance of a surgery not working and that [he] would have had to have a heart transplant," at the very least he would've consulted with his cardiologist, Dr. Brown, and asked for a second opinion. [App. 457 (Tr. p. 1121, l. 25; p. 1122, l. 1-11)] Likewise, he testified in an offer of proof that had he been told he had a "super bad heart and that you were going to have a rough time because you may not have the residual strength to recover," that he would have consulted with Dr. Brown and obtained other doctors' opinions. [App. 507-508 (Supp. Tr. p. 87, l. 18-25; p. 88, l. 1-5)] As Mr. Andersen said, "I would have wanted to know a lot

more about the surgery, and I would have wanted to know what made my chances for survival so much worse than everybody else's." [App. 508 (Supp. Tr. p. 88, l. 9-12)].

Especially because Dr. Khana had never been in an operating room and seen this surgery or done it, including in his residency.

But Mr. Anderson wasn't provided any of that information, and on January 22, 2004, Mr. Andersen underwent the Bentall procedure. [App. 397 (Tr. p.416, l. 17-22)] By all accounts, even in the realm of heart surgeries the Bentall is complicated "because it involves several different components, valve replacement, coronary anatomy . . . a replacement of a great vessel . . . [and] proper myocardial protection in order for the patient to survive." [App. 409 (Tr. p. 544, l. 3-11)]

Things didn't go so well, and after the procedure, Mr. Andersen's left ventricle was not working. [App. 442 (Tr. p. 997, l. 7-11)] After another 1.5 hours, a bypass was performed, and then he was attached to an assist device to "replac[e] the function of the left ventricle." [App. 385 (Tr. p. 347, l. 14-21); App. 443 (Tr. p. 1003, l. 8-14; p. 1004, l. 7-15)] Three days later, he was transferred to the University of Iowa where this temporary pump was replaced with a longer-term device, a HeartMate, which kept his heart pumping until he received a heart transplant about 2.5 years later. [App. 398-

399 (Tr. p. 426, l. 10-25; p. 427, l. 1-8; p. 429, l. 3-10); App. 429 (Tr. p. 856, l. 1-3)]

Not surprisingly, Plaintiffs' experts disagree with the Defendants' with regard to the cause of the failed procedure.

According to Plaintiff's expert, Robert Johnson, M.D. (Dr. Johnson), a cardiothoracic surgeon with more than 26 years of experience, Plaintiff's aortic valve area was only slightly abnormal: "abnormal is less than 1. And his was .8 or .9." [App. 386 (Tr. p. 351, l. 3-15)] Dr. Johnson testified that Mr. Andersen "was a good candidate" for successful aortic and aortic valve replacements, and in fact, that Mr. Andersen's heart pumped "at the normal end of normal," where on a 10-point scale (10 as the best), it rated an 8-8.5 in terms of the likelihood of a successful procedure. [App. 387-388 (Tr. p. 354, l. 3-6; p. 356, l. 4-9; p. 371, l. 2-3); App. 413 (Tr. p. 572, l. 21-25; p. 573, l. 4-5)] Dr. Johnson had done over 100 of the Bentall procedures.

Another Plaintiffs' expert, Dwaine Peetz, M.D. (Dr. Peetz), a cardiovascular and thoracic surgeon also with decades of experience, concurred and testified that Mr. Andersen "was actually an excellent candidate . . . for this procedure." [App. 413 (Tr. p. 573, l. 4-6)] Defendants' expert, cardiothoracic surgeon Robert Love, M.D. (Dr. Love) agreed that Mr. Andersen was a good candidate of whom he "wouldn't have expected

that things would have gone on for him to need a heart transplant," given his condition pre-surgery. [App. 465 (Tr. p. 1165, l. 10-21)]

Dr. Love, Dr. Peetz and Dr. Johnson provided testimony on the applicable standards of care for Mr. Andersen's surgery. Dr. Love stated he would not recommend to his patients a doctor that did not do this operation.

Dr. Johnson testified regarding the appropriate level of preparation necessary to be ready to perform a Bentall operation. [App. 372-373 (Tr. p. 265, l. 25; p. 266, l. 1-2, 20-25; p. 267, l. 17-20; p. 269, l. 23-25; p. 270, l. 1-2)]

Initially, he noted that surgeons receive training for all cardiac operations, and that for complex ascending aortic operations like the Bentall procedure, it is "more difficult to train people." [App. 373-374 (Tr. p. 271, l. 8-16; p. 272, l. 19-24; p. 273, l. 11-17)] In fact, the procedure is so difficult that, despite the fact that the experienced training surgeon is giving step by step instructions, some cardiac surgeons (individuals who have already had five years of general surgery training) do not "perform reasonably well" and "you have to work really hard to get them to do the right moves." [App. 373 (Tr. p. 271, l. 23-25; p. 272, l. 2-4)] This is due to the fact that "it's a complex operation that requires a lot of judgment issues . . . technical skills

being fine . . . knowing how to connect the steps . . . experience, judgment and the wisdom to do." [App. 377 (Tr. p. 294, l. 4-25; p. 295, l. 1-2)]

In order to get them to the point where their "moves" can be evaluated, first the training surgeon performs the surgery and the trainee simply observes; in fact, the trainee does not begin performing any surgery until at least his second time participating in the procedure. [App. 373 (Tr. p. 271, l. 23-25; p. 272, l. 1-9)] As Dr. Peetz testified, "I scrubbed on a few as a resident, and then when I got into practice, it was a senior partner who was with me on several cases. We never did them alone until we had done a number of them." [App. 409 (Tr. p. 544, l. 3-15)] Dr. Love agreed that he had participated in 10-15 Bentall procedures during his residency, and also that he trains residents by having them do "the part that was on the right side," and then observe the remainder of the operation. [App. 466 (Tr. p. 1169, l. 25; p. 1170 entire; p. 1171, l. 1-4)]

During proper instruction, when that trainee first begins performing the surgery, his actions are directed by the training surgeon, he does not "make any judgments during the operation," but rather, as Dr. Johnson explained, "all you have to do is execute the technical moves as I instruct you to do them, and you've seen me do it before." [App. 373 (Tr. p. 272, l. 2-14)]

Dr. Khanna is a board certified, cardiothoracic surgeon, who received five years of general surgery training and two years of cardiothoracic surgery training. [App. 438-439 (Tr. p. 955, l. 3-18; p. 956, l. 1-10; p. 957, l. 6-8)] However, he never sought out, or received, any training in performing the Bentall procedure, and had been practicing for less than three years at the time he performed Mr. Andersen's surgery. [App. 444 (Tr. p. 1008, l. 13-16); App. 439 (Tr. p. 958, l. 6-8)] In fact, Dr. Khanna had never assisted anyone else in performing the surgery, nor had he even been in an operating room when one was performed. [App. 445 (Tr. p. 1010, l. 12-18)] Dr. Peetz testified that performing the complex Bentall procedure without ever having "seen or done" it before was negligent and below the standard of care, and "the experience level of the surgeon was not appropriate for this operation." [App. 409-410 (Tr. p. 545, entire; p. 546, l. 1-7; p. 548, l. 7-18)]

In any event, after receiving thorough and proper training, even experienced heart surgeons, like Dr. Johnson (who has performed about 180 Bentall procedures) often ensure they have another experienced surgeon assisting when they conduct an elective (as opposed to emergency) Bentall operation. [App. 374 (Tr. p. 276, l. 1-13)] Dr. Peetz testified that this is particularly true for the "first several times," the complex Bentall procedure is performed. [App. 416 (Tr. p. 592, l. 1-25)]. The inexperienced Dr. Khana

did the operation solo. Dr. Peetz also noted that in his practice, each time a procedure was refined and he and his partner had to learn how to apply a new device or process, they would ensure they had another experienced surgeon assisting for the first "few procedures . . . two to three to five." [App. 417 (Tr. p. 593, entire; p. 594, l. 1-11)]

Although Mr. Andersen's surgery was arranged well in advance, Dr. Khanna failed to ensure that another surgeon was present during the procedure (until things went horribly wrong), even though he could have had the help of his IHC colleague and mentor, Robert Zeff, M.D. (Dr. Zeff), who had performed 100-150 Bentall surgeries by the time of Mr. Andersen's. [App. 403 (Tr. p. 476, l. 11-25; p. 477, l. 1); App. 444-445 (Tr. p. 1008, l. 24-25; p. 1009, l. 1-7, 18-25; p. 1010, l. 1-5)] Dr. Johnson testified this was well beneath the standard of care. [App. 377 (Tr. p. 294, l. 4-19)]

Plaintiffs' experts testified that these breaches of the standard of care led Dr. Khanna to improperly perform the surgery.

First, it should be noted that in order to operate on a human heart, the flow of blood through and in it must be stopped; yet, absent measures, the heart's cells will die if they don't receive oxygen and nutrients. These measures include completely stopping the heart from moving (fibrillating), and chilling the cells to the point where they are preserved and not striving

for oxygen; this is done primarily through the application of cardioplegia, a solution that paralyzes and preserves the heart muscle. According to Dr. Peetz, it is critical that as soon as the surgeon "stop[s] the blood flow to the heart. Immediately something has to be done to protect that heart muscle. Otherwise, the heart muscle starts to die." [App. 405-406 (Tr. p. 503, l. 8-17; p. 513, l. 5-9)]

In this case, Dr. Khanna did not immediately apply the protective cardioplegia as soon as Mr. Andersen's heart was clamped at 9:58 a.m. [App. 378 (Tr. p. 297, l. 14-19; p. 298, l. 4-21; p. 299, l. 10-15)] Rather, Dr. Khanna waited for four minutes, until 10:02 a.m. to do so; according to Dr. Johnson, because "there is injury of waiting after you put the clamp on" to apply cardioplegia, it breaches the standard of care to wait this long. [App. 378-379 (Tr. p. 299, l. 12-15, 22-24; p. 300, l. 4-25; p. 301, l. 4-5)] Not only was there "no reason for any delay whatsoever," according to Dr. Johnson, that four-minute delay, in which the heart was deprived of blood but not protected by cardioplegia, could have damaged Mr. Andersen's heart and was "beneath the standard of care." [App. 379 (Tr. p. 301, l. 12-21); App. 393 (Tr. p. 400, l. 23-25; p. 401, l. 1-14)] Dr. Peetz agreed and said, "I don't know why you'd wait four minutes before you give cardioplegia, because you are setting up an injury and infarction." [App. 408 (Tr. p. 521, l. 22-25;

p. 522, l. 1-12)] Dr. Love also agreed that "myocardial protection in this case . . . was not what it should have been," and that without protection, "the heart tissue will die during surgery. [App. 467 (Tr. p. 1189, l. 9-16)]

In addition, when the cardioplegia was eventually given, far too little was used to completely stop Mr. Andersen's heart from fibrillating. Dr. Johnson opined that 1,000 cc should have been administered immediately, and Dr. Peetz testified he would've given 2,000 cc in two doses right from the start; but Dr. Khanna applied less than 800 cc (in two doses) at first – an amount far below the standard of care. [App. 381 (Tr. p. 313, l. 6-25; p. 314, l. 1-9; p. 315, l. 1-20); App. 406 (Tr. p. 514, l. 10-18)]

Records indicate that a subsequent infusion of 300 cc of cardioplegia was administered 13 minutes later, and this was interpreted by Dr. Johnson to mean that Dr. Khanna was still trying to stop the heart from fibrillating. [App. 391-392 (Tr. p. 394, l. 2-3; p. 395, l. 24-25; p. 396, l. 1-3)] Dr. Johnson opined that this amount would've been insufficient to completely stop the heart, and this opinion is bolstered by the fact that only 4 minutes later, another 300 cc were administered directly into the main coronary artery, then another infusion only 13 minutes later, and then another 2 minutes after that. [App. 392-394 (Tr. p. 396, l. 10-25; p. 399, l. 3-10; p. 401, l. 13-19; p. 404, l. 24-25; p. 405, l. 1-9)] Note that Dr. Johnson testified

that experienced surgeons prefer to give fewer, larger infusions at 20 minutes apart (or more) as the greater time between infusions gives more time to operate, as "a lot of times you can't see to put the stitches in or cut the valve out or things when it's flooding." [App. 393 (Tr. p. 401, l. 22-25; p. 402, l. 1-20)] Dr. Peetz agreed and averred that he was "appalled at the small number of cc's, small amount of fluid that was given to the heart muscle," which he claimed "was a demonstration of seriously inadequate cardioplegia," and a breach of the standard of care. [App. 406-408 (Tr. p. 513, l. 10-21; 518, l. 19-25; p. 519, l. 1-2)]

Importantly, the protocol described by Dr. Johnson, with 1000 cc given initially and subsequent infusions every 20 minutes, was precisely that outlined by Dr. Khanna on the preference sheet of instructions he provided to the operating room staff – yet inexplicably failed to follow. [App. 395-396 (Tr. p. 409, l. 24-25; p. 410, l. 14-15; p. 411, l. 4-20)]

In any event, according to Dr. Johnson, Dr. Khanna's "cardiac preservation management was beneath the standard of a reasonable cardiac surgeon." [App. 394 (Tr. p. 406, l. 3-7)]

Dr. Peetz agreed and testified that Mr. Andersen suffered serious tissue damage and scarring as a result of this insufficient stunning and chilling of the heart with cardioplegia, since it left the heart's cells still

striving for oxygen and nutrients that weren't coming – and ultimately to their death; even the Defendants' expert, Dr. Cuenoud, agreed that Mr. Andersen's heart "suffered from that surgery" due to scarring. [App. 407 (Tr. p. 515, l. 1-20); App. 410 (Tr. p. 549, l. 7-20); App. 453 (Tr. p. 1065, l. 13-19)]

Aside from improper myocardial protection due to inadequate cardioplegia, Plaintiffs' experts testified Dr. Khanna breached other standards of care with his performance of the procedure, as well.

Dr. Johnson testified that Dr. Khanna also breached the standard of care when he performed an unnecessary extra step, by going beyond "a supercoronary graft," and removing the "portion of the aorta below the sinotubular ridge." [App. 377 (Tr. p. 293, l. 1-23)] More particularly, he improperly performed the graft when he re-attached the aorta in such a way that it narrowed the artery, thereby restricting blood flow and leading to the left side of Mr. Andersen's heart being unable to properly function. [App. 379-380 (Tr. p. 304, l. 4-7; p. 306, l. 1-6); App. 382-384 (Tr. p. 332, l. 1-14; 333, l. 6-25; p. 334, l. 1-3; p. 337, l. 4-9; p. 339, l. 5-11)]

In addition, both Dr. Johnson and Dr. Peetz testified that Dr. Khanna breached the standard of care by waiting too long to realize Mr. Andersen's heart's left side required a coronary bypass; Dr. Peetz averred that it should

have been decided within 20 minutes, and Dr. Johnson testified the entire bypass should have been completed within 35 minutes after the clamp (that restricted blood flow to the heart during surgery) was removed; however it took Dr. Khanna 89 minutes to complete the bypass. [App. 385-386 (Tr. p. 345, l. 9-15; p. 346, l. 10-18; p. 347, l. 14-21; p. 349, l. 3-10); App. 412 (Tr. p. 569, l. 3-16)]

## **ARGUMENT**

### **I. THE TRIAL COURT ERRED WHEN IT DENIED PLAINTIFFS THE OPPORTUNITY TO PRESENT THEIR CLAIM OF NEGLIGENT FAILURE TO OBTAIN INFORMED CONSENT TO THE JURY.**

#### **A. Preservation of error and standard of review**

This issue was "both raised and decided by the district court" pursuant to the trial, and the parties' respective motions and resistances, including Plaintiffs-Appellants' Motion for a New Trial and Supplemental Motion for New Trial, as well as in oral argument, and, therefore, has been preserved for review. *Meier v. Senecaut*, 641 N.W.2d 532, 537 (Iowa 2002). The standard of review of a district court's grant of summary judgment is for correction of errors at law, and the appellate court will affirm the district court's judgment, "only when the entire record establishes no genuine issue

of material fact." *Hlubek v. Pelecky*, 701 N.W.2d 93, 95 (Iowa 2005); Iowa R. App. P. 6.907; Iowa R. Civ. P. 1.981(3).

Evidence must be viewed in the "light most favorable to the non-moving party," and all reasonable inferences that can be made from the record must be afforded to the non-moving party. *Coralville Hotel Assocs., L.C. v. City of Coralville*, 684 N.W.2d 245, 247 (Iowa 2004). A jury question may even be generated on undisputed facts where, through the application of the appropriate legal standard, different conclusions could be reached. *Hoekstra v. Farm Bureau Mutual Ins. Co.*, 382 N.W.2d 100, 108 (Iowa 1986).

The scope of review of "the denial of a motion for new trial" depends upon the "grounds asserted in the motion." *Fry v. Blauvelt*, 818 N.W.2d 123, 128 (Iowa 2012). A district court's decision to exclude evidence is reviewed for abuse of discretion, which occurs when the court rules "on grounds or for reasons clearly untenable or to an extent clearly unreasonable." *Hall v. Jennie Edmundson Memorial Hosp.*, 812 N.W.2d 681, 685 (Iowa 2012); *State v. Richards*, 809 N.W.2d 80, 89 (Iowa 2012).

**B. Dr. Khanna breached his duty of care to obtain Plaintiffs' informed consent prior to performing the procedure.**

**1. Dr. Khanna had a duty to inform Plaintiffs that Mr. Andersen had a "super weak heart" with potentially insufficient "reserves" to survive the procedure.**

According to the Defendants' theory, the reason the procedure failed was that Mr. Andersen's really bad heart went into the surgery with insufficient strength to survive it. Yet this risk was never told to the Plaintiffs, in violation of Iowa law.

"[N]o valid reasons exist[] for allowing the medical community the exclusive determination of what information would be material to a patient's decision to consent to a particular medical procedure . . . [and as such] the patient rule is applicable in all informed consent cases . . . ." *Pauscher v. Iowa Methodist Medical Center*, 408 N.W.2d 355, 359 (Iowa 1987) This rule accepts the fact that, "the decision to consent to a particular medical procedure is not a medical decision [but i]nstead . . . is a personal and often difficult decision to be made by the patient with the physician's advice and consultation." *Pauscher*, 408 N.W.2d at 360.

To establish a breach of the duty to obtain informed consent, Plaintiffs must show: "(1) the existence of a material fact unknown to the patient; (2) a failure to disclose that risk on the part of the physician; (3) disclosure of the risk would have led a reasonable patient in plaintiff's position to reject the medical procedure or choose a different course of treatment; and (4) injury." *Pauscher*, 408 N.W.2d at 360. Each of these elements is present in this case.

Plaintiffs have testified that after consultation with all of their doctors, including Brown, Chawla and Khanna, they thought that Mr. Andersen's procedure would be routine for a heart surgery; in fact, Mr. Andersen specifically testified in an offer of proof that Dr. Khanna did not "in any way inform [him] that [he] had a super bad heart for an elective surgery that was more difficult than the traditional Bentall elective surgery." [App. 508 (Supp. Tr. p. 88, l. 21-25)]

Yet, according to Defendants' experts, Mr. Andersen's surgery was more difficult than the traditional surgery, and, before it was performed, it was known that his "super bad heart" was at significant risk for having insufficient reserves to survive it; clearly this is a material fact.

Neither Dr. Chawla nor Dr. Khanna disclosed this risk, although, according to Dr. Eales, it is one he commonly discusses with his patients.

In addition, Mr. Andersen testified that had he been given the information about his greater risk, he would have asked the opinions of other doctors, and particularly, of Dr. Brown and his colleagues at the University of Iowa, at the very least to determine why his risk was so much greater. But, of course, he wasn't told, he underwent the procedure in ignorance and lost his heart because of it.

Under Iowa informed consent law, "the patient ordinarily will be required to present expert testimony relating to the nature of the risk and the likelihood of its occurrence, in order for the jury to determine, from the standpoint of the reasonable patient, whether the risk is in fact a material one." *Estate of Anderson v. Iowa Dermatology Clinic, PLC*, 819 N.W.2d 408, 416-17 (Iowa 2012); *see also Cox v. Jones*, 470 N.W.2d 23, 27 (Iowa 1990)(noting that where a plaintiff's claims were "all issues beyond the common knowledge of laypersons," expert evidence was required).

As noted above, the expert testimony of Dr. Eales was provided where he discussed his procedure for informing patients with "super bad hearts" of this risk.

However, as the rule notes, expert testimony is "ordinarily, " but not always, required. As such, the risks deriving from complex medical conditions and procedures, such as a retinal detachment or a reverse intestinal bypass, require expert testimony to establish a lack of informed consent. *See Kennis v. Mercy Hosp. Medical Center*, 491 N.W.2d 161, 166 (Iowa 1992).

And in the present case, Plaintiff was prepared to present that expert testimony – from Dr. Aroesty, but was prevented from doing so by the trial court's order.

Nonetheless, the deficiency purportedly known to (but not disclosed by) Dr. Khanna, that Mr. Andersen's heart was extraordinarily weak, even for someone who was a good candidate for a Bentall procedure, is something well within the understanding of lay people, and as such expert testimony is not required. *See Cox*, 470 N.W.2d at 27 (noting that the requirement of expert testimony is merely the "general rule" and that "exceptions . . . are recognized through a showing that even laypersons could comprehend a physician's lack of care . . . .")

This is supported by the fact that the duty "is shaped not by what the medical community would deem material, but by the patient's need for information sufficient to make a truly informed and intelligent decision." *Bray v. Hill*, 517 N.W.2d 223, 225 (Iowa Ct. App. 1994).

As such, in certain circumstances as in the present case, because the nature of the risks were within the common knowledge of laypersons, expert testimony was not required. *See Cox*, 470 N.W.2d at 26

Clearly, any reasonable adult would find the fact that he had a "super bad heart" that may not have enough "reserves" to survive a procedure material and important, and necessary to disclose, as demonstrated by Mr. Andersen in his offer of proof:

Q. If you had been told that by Dr. Khanna when you had your initial session with him, that is, you had a super bad

heart and that you . . . may not have the residual strength to recover during surgery, what would you have done?

A. I would have called my cardiologist in Iowa City [Dr. Brown], talked to him . . . .

Q. Would you have in any way, shape, or form proceeded to allow Dr. Khanna to schedule you for an operation before consulting other doctors?

A. No, absolutely not. . . . I would have wanted to know a lot more about the surgery, and I would have wanted to know what made my chances for survival so much worse than everybody else's. . . .

Q. And do you believe that you were entitled to this information before they put you at risk of having your heart killed during the surgery?

A. Yes, I do.

[App. 507-508 (Supp. Tr. p. 87, l. 16-25; p. 88, l. 1-20)]

Clearly, the importance of this information and the risk it posed was within the understanding of this layperson, but he was never given this information, and instead was misled to believe he may even be well enough to travel after a few months. This is the definition of failure of the duty to obtain informed consent, and Plaintiffs were entitled to have the opportunity to present their case. *See Pauscher*, 408 N.W.2d at 360.

Thus, the evidence presents a genuine issue of material fact on the issue of informed consent, and as such, the trial court's initial grant of summary judgment on this issue was error. *See Hlubek*, 701 N.W.2d at 95.

Likewise, its refusal to allow evidence on this issue, as well as grant a new trial due to its absence, was an abuse of discretion. *Hall*, 812 N.W.2d at 685

**2. Dr. Khanna had a duty to inform Plaintiffs that he had no training and no experience in performing a Bentall procedure.**

Both Dr. Johnson and Dr. Peetz testified as to the importance of training and experience in performing a Bentall surgery, and in fact, both testified that Dr. Khanna breached the standard of care when he conducted the surgery without any. Clearly, these two distinguished heart surgeons considered this a material fact; of course, it was not disclosed to Mr. Andersen who testified in an offer of proof that it would have led him to a different course of treatment:

Q. Would you have been more vigilant about whether the doctor that was doing this was experienced in difficult Bentall surgery?

A. I would have wanted to know a lot more about the surgery . . . .

Q. Would you have wanted to go to a surgeon that had plenty of experience on these difficult surgeries?

A. Yes, I would have.

Q. And do you believe that you were entitled to this information before they put you at risk of having your heart killed during the surgery?

A. Yes, I do.

[App. 508 (Supp. Tr. p. 88, l. 6-20)]

Note that Mr. Andersen's assessment of his risk is the same as any other reasonable patient in his position; in fact, studies have shown that patients place a surgeon's specialized training and significant experience as the most important factors when choosing one. *See* Aslam Ejaz, MD, MPH, et al., *Choosing a Cancer Surgeon: Analyzing Factors in Patient Decision Making Using a Best-Worst Scaling Methodology*, 21 *Annals of Surgical Oncology* (12)(Nov. 2014). Perhaps this is because they know that the more surgeries a physician performs, the better the outcomes for the patient. *See* Vivian Ho, Ph.D. and Martin J. Heslin, M.D., 13 *Annals of Surgical Oncology* (6) (June 2006).

Clearly, the record demonstrates that Plaintiffs have established that Dr. Khanna's failure to disclose his lack of training and experience is a breach of his duty to obtain informed consent. *Pauscher*, 408 N.W.2d at 360. However, the trial court disagreed with this proposition, basing its decision on the fact that it could find no authority, either in Iowa or nationally, to support the claim.

Thankfully, the types of negligent misrepresentations and omissions like those (not) made by Dr. Khanna are rare, but in those cases where it occurs, jurisdictions that follow the “patient rule” have found that certain misrepresentations and omissions do support an informed consent claim.

For example, the Maryland Court of Appeals found a physician negligent for failing his duty of informed consent on similar facts. *See Goldberg v. Boone*, 912 A.2d 698, 702 (Md. Ct. App. 2006). In *Goldberg*, the Maryland court approved the trial court's decision to submit the issue of lack of informed consent to the jury, noting, "the combination of having [a super bad dura] which elevated the complexity of his revisionary mastoidectomy, with the fact that [the doctor] had performed only one [such surgery] over the past three years . . . gave rise to [the doctor's duty] to inform him that there were other more experienced surgeons . . . [and this presented] a factual issue for the jury to determine whether a reasonable person, in Mr. Boone's position, would have deemed this information material. . . ." *Id.* at 717.

Likewise, the Wisconsin Supreme Court found that where a physician materially misrepresented the risks of a surgery, by falsely claiming that he "had operated on aneurysms comparable" to that of the plaintiff's "dozens of times," when in fact he had only performed the surgery twice and never on one as complex and large as the plaintiff's, "a reasonable person in the plaintiff's position would have considered such information material in making an intelligent and informed decision about the surgery." *Johnson by Adler v. Kokemoor*, 545 N.W.2d 495, 499, 505 (Wis. 1996)

Note that both the Maryland and Wisconsin courts believed that the doctors' failures to inform the patients that "there are other, more experienced surgeons in the locality," was sufficiently material regarding the risk involved as to support an informed consent claim. *See Goldberg*, 912 A.2d at 715-16 (noting that the "adequacy of the explanation given by the physician in obtaining the patient's consent" may include the "level of a physician's experience"); *Johnson*, 545 N.W.2d at 505 (where the court noted, "had a reasonable person in her position been aware of the defendant's relative lack of experience in performing" such a complex surgery with such serious consequences for failure, "that person would not have undergone surgery with him"); *Johnson*, 545 N.W.2d at 490 (as a result of the surgery, which was deemed a "technical success," Ms. Johnson, "who had no neurological impairments prior to surgery was rendered an incomplete quadriplegic.")

Other courts that also use a patient-oriented standard for informed consent have agreed. *See Moore v. Regents of the Univ. of Cal.*, 793 P.2d 479, 482-484 (1990) (noting the doctrine of informed consent was broad enough to encompass the failure to disclose the doctor's research and financial interest in harvesting the leukemia-patient/plaintiff's cells to develop a lucrative cell line); *Barriocanal v. Gibbs*, 697 A.2d 1169, 1170,

1172 (Del. 1997)(where the court upheld a claim of lack of informed consent based on the defendant-doctor's failure to disclose "the paucity of his recent" experience); *Hidding v. Williams*, 578 So.2d 1192, 1198 (La. Ct. App. 1991)(noting a doctor's failure to disclose "the most feared" complication of a surgery supported a claim for lack of informed consent).

"The patient's right to make an intelligent and informed decision cannot be exercised when information material to that decision is withheld." *Pauscher*, 408 N.W.2d at 360. Clearly, Dr. Khanna's lack of training and experience was material and, if disclosed, would've changed Mr. Andersen's course of treatment since the failure to disclose led to Plaintiff's injuries. *Id.*

Therefore, the evidence presents a genuine issue of material fact on the issue of informed consent, and as such, the trial court's initial grant of summary judgment on this issue was error. *See Hlubek*, 701 N.W.2d at 95. Likewise, its refusal to allow evidence on this issue, as well as grant a new trial based on its absence, was an abuse of discretion. *Hall*, 812 N.W.2d at 685.

## **II. THE TRIAL COURT ERRED IN REFUSING TO ALLOW PLAINTIFFS TO PRESENT REBUTTAL TESTIMONY FROM PLAINTIFFS AND FROM DR. AROESTY TO ADDRESS THE DEFENSE'S EXPERT TESTIMONY THAT PLAINTIFF HAD A "SUPER BAD HEART" WITH INSUFFICIENT RESERVES THAT CREATED A GREATER RISK THAT IT WOULD FAIL.**

### **A. Preservation of error and standard of review**

This issue was "both raised and decided by the district court," pursuant to the trial, and the parties' respective motions and resistances, including Plaintiffs-Appellants' Motion for a New Trial and Supplemental Motion for New Trial, as well as in oral argument, and, therefore, has been preserved for review. *Meier*, 641 N.W.2d at 537.

The scope of review of "the denial of a motion for new trial" depends upon the "grounds asserted in the motion." *Fry*, 818 N.W.2d at 128. A district court's decision to exclude evidence is reviewed for abuse of discretion, which occurs when the court rules "on grounds or for reasons clearly untenable or to an extent clearly unreasonable." *Hall*, 812 N.W.2d at 685; *Richards*, 809 N.W.2d at 89. Likewise, the refusal to allow rebuttal evidence is reviewed for abuse of discretion. *Carolan v. Hill*, 553 N.W.2d 882, 889 (Iowa 1996).

### **B. The trial court erred when it refused to allow Plaintiffs to present rebuttal testimony.**

After Drs. Cuenoud and Eales testified that Mr. Andersen had a "weak," and "super bad heart," that, before the surgery, was like that of a runner after a marathon, and thus had insufficient reserves such that it was more likely to not survive the Bentall procedure, Plaintiffs were denied the opportunity to present testimony, in rebuttal, of the fact that they were never given this information. The trial court justified this decision by again holding that informed consent was out of the case.

However, the trial court ignored the prejudice to Plaintiffs' case caused by this testimony, along with Dr. Eales other testimony where he described how he typically satisfied the requirements of informed consent prior to heart surgery: "When I operate on somebody, I frequently tell them this . . . The fact we can do this successfully depends on whether the people have reserve capacity in their heart." [App. 495 (Supp. Tr. p. 36, l. 8-22)]

Along with the fact that Plaintiffs presented no other testimony to the jury regarding what they were told of these risks prior to the surgery, altogether this testimony (and lack thereof) gives the impression that Mr. Andersen knew all of the risks, and simply chose to take those risks with his super bad heart.

As has been observed by other courts, even with a "curative instruction . . . we cannot overlook the prejudicial effect this testimony may

have had in combination with the other unfair elements of [the] trial." *U.S. v. Delgado*, 631 F.3d 685, 706 (5th Cir. 2011). As noted by the Fifth Circuit, "if you throw a skunk into the jury box, you can't [expect] the jury not to smell it." *Id.* This is why rebuttal evidence was required.

Having a direct tendency to explain, repel, controvert or disprove evidence "produced by the other party," relevant evidence is admissible on rebuttal, and a trial court's refusal will be reversed when it "take[s] away the opportunity to present proper rebuttal evidence." *See Johnson v. Van Werden*, 125 N.W.2d 782, 785 (Iowa 1964)("We wish to emphasize our disapproval of trial procedure whereby a party is deprived of the opportunity to present rebuttal evidence . . . ."); *Carolan*, 553 N.W.2d at 889.

In fact, even where relevant evidence was properly excluded for presentation during a party's case-in-chief, it may still be admissible in rebuttal to disprove the "evidence produced by the other party." *See Salami v. Von Maur, Inc.*, No. 3-346/ 12-0639, at \*17 (Iowa Ct. App. 2013). This is so particularly where the other party's evidence renders plaintiff's allegation "less probable than it would be without the evidence." *Salami*, at \*19. Thus, since Defendants raised the issue of informed consent, "[a]t that point, the plaintiff should have been allowed to respond with evidence contradicting [defendant's witness'] testimony," if available. *Id.*

In addition to discrediting the notion that Plaintiffs knew the risks and chose to take them, allowing Mr. Andersen to testify that he was not informed of those risks was admissible and probative for its tendency to disprove Defendants' theory that Mr. Andersen's super bad heart, and not Dr. Khanna's negligence, was to blame.

Evidence that neither Dr. Brown nor Dr. Chawla, in addition to Dr. Khanna, informed Mr. Andersen of any increased risk can readily be interpreted to mean that neither the consulting physicians nor the surgeon thought Mr. Andersen's heart was "super bad;" and, since neither of the experienced cardiologists, who examined his heart *pre-surgery*, identified any of the risks claimed by Defendants' experts, then it is more likely that they did not exist, and, therefore, the surgery didn't fail because of Mr. Andersen's weak heart, but rather due to Dr. Khanna's negligence.

Clearly, relevant, material testimony such as this is admissible, and should have been allowed. *Salami*, at \*17, 19. Therefore, the trial court's refusal to allow Plaintiffs' rebuttal testimony was clearly unreasonable, for untenable grounds, and an abuse of discretion, justifying reversal of its refusal to grant Plaintiffs a new trial. *Hall*, 812 N.W.2d at 685; *Carolan*, 553 N.W.2d at 889.

**III. THE TRIAL COURT ERRED WHEN IT REFUSED TO ALLOW PLAINTIFFS TO PRESENT A SPECIFICATION OF NEGLIGENCE FOR DR. KHANNA'S FAILURE TO HAVE SUFFICIENT TRAINING AND EXPERIENCE TO CONDUCT THE SURGERY.**

**A. Preservation of error and standard of review**

This issue was "both raised and decided by the district court" pursuant to the parties' respective motions and resistances, including Plaintiffs-Appellants' Motion for a New Trial and Supplemental Motion for New Trial, as well as in oral argument, and, therefore, has been preserved for review. *Meier*, 641 N.W.2d at 537.

The scope of review of "the denial of a motion for new trial" depends upon the "grounds asserted in the motion." *Fry*, 818 N.W.2d at 128. A district court's refusal to give a party's requested jury instruction is reviewed for abuse of discretion. *Mulhern v. Catholic Health Initiatives*, 799 N.W.2d 104, 110 (Iowa 2011); *Cagle v. Pilot Travel Ctrs., L.L.C.*, 821 N.W.2d 286 (Iowa Ct. App. 2012)

"When weighing the sufficiency of evidence to support a requested instruction, we construe the evidence in a light most favorable to the party seeking submission." *Sonnek v. Warren*, 522 N.W.2d 45, 47 (Iowa 1994). Error in refusing to give a particular jury instruction merits reversal when it prejudices the party challenging the refusal. *Cagle*.

**B. The trial court erred in failing to include in the jury instructions the specification that Dr. Khanna was negligent for performing a surgery that he had no inexperience with and was not trained for.**

"Parties to lawsuits are entitled to have their legal theories submitted to a jury if they are supported by the pleadings and substantial evidence in the record." *Sonnek*, 522 N.W.2d at 47. Provided a requested instruction "correctly states the applicable law and is not embodied in other instructions," Iowa law mandates that it be given to the jury. *Id.*

Specifications in jury instructions are favored under Iowa law. *See Mulhern*, 799 N.W.2d at 121. This is particularly true for those that "explicitly set forth the particular acts or omissions constituting negligence." *Mulhern*, 799 N.W.2d at 121 (noting "the purpose of requiring a jury to consider specifications of negligence is to limit the determination of factual questions to only those acts or omissions upon which a particular claim is based.")

Proper specifications "identify either a certain thing the allegedly negligent party did which that party should not have done, or a certain thing that party omitted that should have been done, under the legal theory of negligence that is applicable." *Coker v. Abell-Howe Co.*, 491 N.W.2d 143, 151 (Iowa 1992)

Drs. Johnson and Peetz both testified that when Dr. Khanna performed the Bentall procedure on Mr. Andersen with no training and no experience this was below the standard of care, and, therefore, negligent. *See* Restatement (Second) of Torts § 300 (stating to avoid negligence, a person must make those preparations that, "a reasonable man in his position would recognize as necessary to prevent the act from creating an unreasonable risk of harm to another.") Clearly, therefore, a specification in the jury instructions, that it could find him negligent for attempting to perform the surgery when unqualified, was warranted. *See Mulhern*, 799 N.W.2d at 121.

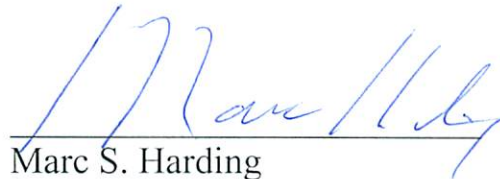
Furthermore, the record is filled with evidence that he was unqualified, including that he failed to ensure another surgeon (with experience) assisted with the procedure, that he failed to properly chill the heart, and that he delayed at several points during the procedure – all contributing to Mr. Andersen's injuries. Taking this evidence in the light most favorable to Plaintiffs, it is clear that the refusal to include this specification prejudiced them, thus justifying reversal of the trial court's refusal to grant Plaintiffs' motion for a new trial. *Sonnek*, 522 N.W.2d at 47; *Cagle*.

## **CONCLUSION**

For the reasons aforesaid, Plaintiffs-Appellants request this Honorable Court to enter an Order reversing the trial court and granting Plaintiffs-Appellants' motion for a new trial.

## **REQUEST FOR ORAL SUBMISSION**

Counsel for Appellant respectfully requests that they be heard in oral argument upon submission of this case.



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